LA CROSSE COUNTY DEPARTMENT OF HUMAN SERVICES
PURCHASE OF SERVICE CONTRACT

CONTRACT NUMBER 04-0000

I. PARTIES:

A. This contract is made and entered into this 1st day of January, 2004, by and between La Crosse County, a Wisconsin municipal body corporate represented by the La Crosse County Department of Human Services, hereinafter referred to as Purchaser, and ABC Corporation, hereinafter referred to as Provider. This contract is to be effective for the period January 1, 2004 through April 31, 2004.

II. CONTACT PERSONS AND CONTRACT ADMINISTRATORS:

A. Purchaser's employee responsible for administration of this contract will be Gerald R. Huber, whose principal business address is 300 N 4th Street, La Crosse, WI 54601. Provider's employee responsible for administration of this contract is Jane Doe, whose principal business address is 1234 State Street, La Crosse, WI 54601. If either party changes its contract administrator, it will notify the other party of the name and address of the new contact person in writing within 10 days of the change.

III. PURPOSE:

A. It is understood that Purchaser has entered into contracts with various departments of the State of Wisconsin. The purpose of this contract is to formalize the terms and conditions of the Provider's services to eligible clients receiving authorized services.

IV. STATUS OF PARTIES:

A. Purchaser and Provider agree that each acts in an independent capacity in the performance of this contract and not as an employee or agent of the other.

B. Nothing contained in this Contract shall constitute or be construed to create a partnership or joint venture between the Purchaser and its successors or assigns and Provider or its successors or assigns. In entering into the Contract and in acting in compliance herewith, Provider is at all times acting and performing as an independent Provider, duly authorized to perform the acts required of it hereunder.

C. The Provider shall ensure that staff providing services are properly supervised and trained and that they meet all of the applicable licensing and certification requirements.

V. PAYMENT FOR SERVICE:

A. Method of payment will be the following (check all that apply):

_____ 1. Purchaser will reimburse Provider monthly, based upon billed authorized units of service delivered at the agreed upon unit rate.

_____ 2. Purchaser will reimburse Provider monthly based upon $1/12^{th}$ of the estimated total Contract. The final payment will be adjusted to reflect the total billed and authorized units of service provided during the contract period, at the agreed upon unit rate. See page 12 - Method of Payment requirements.

_____ 3. Purchaser will reimburse Provider monthly based on current Medical Assistance (MA) rates as published by the Wisconsin Medical Assistance Program.

B. Purchaser agrees to pay Provider for the services provided in accordance with this contract at the rate(s) specified in Appendix 1. Payment for Medicaid state plan services (as specified in s. 49.46 (2) Wis. Stats. and HFS 107 Wis. Admin. Code) for Medicaid recipients who are covered clients will occur through the Medicaid program in accordance with the Medicaid program policies and procedures.

C. Provider agrees to bill Purchaser by the 5th of each month, but no later than ninety (90) days from the time the services were provided, unless parties agree to a longer period of time. In the case where the provider is awaiting a response from other third party payers, the provider shall submit the bill to the purchaser within forty-five (45*)* days from getting a response from all third party payers, but within a year from the date the service was provided. However, all billings and/or report of outstanding expenses shall be submitted to Purchaser no later than January 31st of the following year to be considered for payment (This sentence does not apply to services provided for the Care Management Organization-CMO). This report of outstanding expenses should include any claims that are still outstanding and/or waiting for a response from other third party payers, that could possibly be billed to the Purchaser.

D. Claims will be submitted on forms deemed appropriate by Purchaser as documentation of services provided. If applicable, Provider agrees to bill and collect payment from other third party payers (Medicare, insurance, other health liability) prior to submitting bills to Purchaser. Purchaser will in this case be the payer of last resort.

E. For services performed under this contract and provided to an eligible client, the Provider agrees to accept payments made by the Purchaser and/or any third party payers as payment in full and will not bill clients or the Wisconsin Department of Health and Family Services for amounts not fully paid by the Purchaser. This provision continues in effect even if the Purchaser becomes insolvent.

F. Purchaser shall reject any claim that does not include the elements of a clean claim. Purchaser shall send the rejected claim back to the Provider for correction.

G. Elements of a clean claim are as follows:
    a. Client Name
    b. Number of units of service provided by day or by month.
    c. Total fee
    d. Amount paid by third party payer (if applicable)
    e. Net fee
    f. Dates of Service (one calendar month on an invoice)
    g. If applicable, HSRS item codes (This number is listed as the SPC Code on the Service Authorization)
    h. Contract Rate

VI. RECORDS AND REPORTING:

A. The Provider shall maintain such records and financial statements as required by Local, State and Federal laws, rules and regulations.

B. Individuals shall have to their records in accordance with applicable state or federal law. Provider shall use its best efforts to make records available to eligible clients or their authorized representatives within ten (10) working days of the record request.

C. Provider shall have procedures to provide for the prompt transfer of records and exchange of information to Purchaser and other providers for the purposes of managing the eligible client's medical and long term care and providing referral services.

D. The use or disclosure by any party of any information concerning eligible clients who receive services from Provider for any purpose not connected with the administration of Provider’s and Purchaser’s responsibilities under this contract is prohibited except with the informed, written consent of the person or their legal guardian.

E. The Provider shall comply with the reporting requirements of Purchaser. All reports shall be in writing and, when applicable, in the format specified by the Purchaser.
F. Provider shall maintain and, upon request, furnish to Purchaser any and all information requested by Purchaser relating to the quality and quantity of services covered by this contract.
G. Provider shall maintain written description of care and service verification, including the dates of services performed for all the purchased services rendered, as specified by Purchaser. Provider shall maintain clearly identified and readily accessible documentation of costs supported by properly executed payrolls, time records, invoices, contracts, vouchers or other official documentation evidencing in proper detail the nature and propriety of the services provided.
H. Provider agrees to maintain and preserve its accounting and other financial management records pertaining to this contract in a form and manner consistent with all applicable state and federal laws and principles of proper accounting and financial management.
I. If the Provider subcontracts any part of this Contract, the Provider is responsible for fulfillment of the terms of the Contract and shall give prior written notification of such subcontracting to the Purchaser for approval.

VII. CLAIMS DISPUTE, COMPLAINTS AND GREIVANCES:

A. If Provider wishes to dispute a claim denial or claims payment, it may request that the Purchaser reconsider its action by filing a written request with Purchaser's Financial Manager within sixty (60) days of Purchaser action. Provider may appeal Purchaser's reconsideration decision for failure of the Purchaser to respond within forty-five (45) days of a reconsideration request, by filing a written request to the DHFS or DWD within sixty (60) days of the Purchaser's final decision or failure to respond. In filing a request for reconsideration or appeal, Provider shall clearly mark it as an "appeal" and indicate the Provider's name and address, date of service, date of billing, date of rejection, and reasons for Provider's request for reconsideration or appeal.
B. Purchaser shall be notified in writing of all written complaints filed against the Provider. Provider agrees to fully cooperate with Purchaser in researching and resolving complaints and grievances regarding Provider's services. Such cooperation will include furnishing information to Purchaser within fifteen (15) working days of its request, or within requested number of working days if the grievance is expedited. Purchaser shall inform the Provider in writing with their understanding of the resolution of the complaint.

VIII. ACCESS TO SERVICES, PREMISES AND RECORDS:

A. Provider must not create barriers to access of necessary services by any requirements it imposes. At Purchaser's request, Provider will submit to Purchaser any policies and procedures it develops that are material to providing services so that Purchaser is able to assure that barriers are not created.
B. Provider shall allow duly authorized representatives of the Purchaser, DHFS/DWD, or federal Department of Health and Human Services, during normal business hours, access to its premises to inspect, audit, monitor or otherwise evaluate the performance of Provider and its subcontractors, if any. In the event access is requested, Provider shall make staff available to assist in the audit or inspection effort and provide adequate space on the premises to reasonably accommodate personnel. All inspections and audits will be conducted in a manner that will not unduly interfere with the performance of the Provider's activities.
C. Purchaser and duly authorized state and federal representatives shall have the right upon request to inspect, examine, or copy records, including individual records, pertaining to this contract and maintained by the Provider.
D. Provider shall permit appropriate representatives of the Purchaser to have timely access to the Provider’s records and financial statements as necessary to review Provider’s compliance with contract requirements for the use of the funding.

IX. WITHHOLDING:

A. Purchaser may withhold any and all payments otherwise due Provider if Provider fails to perform in accordance with this contract, and may hold the payments until Provider corrects its failure to perform.

B. Purchaser may withhold any and all new authorizations and/or admissions if Provider is found to be in violation of this contract.

X. LIABILITY OF PURCHASER:

A. Purchaser and Provider acknowledge that Purchaser has legal liabilities under its contract with DHFS/DWD and that nothing herein shall relieve, or be construed to relieve, Purchaser of its obligations under that contract. Any term in this contract that is later determined to be inconsistent with Purchaser's obligations under its contract with DHFS/DWD, or that in any way terminates Purchaser's legal liability to DHFS/DWD, shall become null and void.

XI. LICENSURE AND CERTIFICATION:

A. If applicable, Provider shall maintain all required licensure, certification, and/or accreditation during the term of this contract and will provide evidence of such upon request of the Purchaser.

B. Provider shall immediately notify Purchaser of any changes or threatened changes to its Medicaid certification/licensure or other certification or accreditation.

XII. EXCLUSION FROM STATE AND FEDERAL HEALTH CARE PROGRAMS:

A. Both parties represent and warrant that Provider and Purchaser and their owners and employees are not excluded from participation, in any Federal health care programs, as defined under 42 U.S.C. Wis. Stats. 1320a-7b(f), or any form of state Medicaid program, and to each party's knowledge, there are no pending or threatened governmental investigations that may lead to such exclusion. Each party agrees to notify the other party of the commencement of any such exclusion or investigation within seven (7) business days of first learning of it. Both parties shall have the right to immediately terminate this contract upon learning of any such exclusion and shall be kept appraised by the other party of the status of any such investigation.

XIII. QUALITY ASSURANCE/QUALITY IMPROVEMENT PROGRAMS

A. Provider agrees to participate to the extent requested by Purchaser in Purchaser’s quality assurance/quality improvement programs and procedures.

B. The Provider will work collaboratively with Purchaser to develop a program evaluation plan for continued improvement in the service delivery area.

C. Provider shall meet all reporting requirements imposed by Purchaser for the purposes of reviewing and auditing Provider's performance under this contract and Purchaser's performance under its contract with DHFS/DWD. Specifically, Provider shall timely provide all utilization data, in the format specified by Purchaser, which is requested by Purchaser related to Provider's quality assurance/quality improvement programs and utilization review.

D. If applicable, the Provider will develop and implement a method to annually evaluate the satisfaction of CBRF residents and their families in accordance with HFS 83.32(2)(c)1.

E. Wisconsin Works (W-2) Providers should refer to Appendix 6 for specific requirements under this contract.

F. Care Management Organization (CMO) providers of Traditional Medical Assistance Services are not required to develop and submit a program evaluation plan to Purchaser.

G. Appendix 8 of this Contract contains Care Management Organization (CMO) Provider Performance Measures for Vocational Services; Residential Services; and/or Adaptive Aids, Disposable Medical Supplies and Durable Medical Equipment. If Provider is contracted for these services, Provider will be expected to meet these Provider Performance Measures.

XIV. SAFETY:

A. Provider attests to meeting all applicable OSHA requirements and similar state and federal laws. If requirements and laws conflict, Provider attests to meeting the most stringent.

XV. INDEMNIFICATION:

A. The Provider agrees to the fullest extent permitted by law, to indemnify, defend and hold harmless, the Purchaser, and its agents, officers and employees, from and against all loss or expense including costs and attorney's fees by reason of liability for damages including suits at law or in equity, caused by any wrongful, intentional, or negligent act or omission of the Provider, or its (their) agents and/or subcontractors which may arise out of or are connected with the activities covered by this Contract. Provider shall indemnify and save Purchaser harmless from any award of damages and costs against Purchaser for any action based on U.S. Patent or Copyright infringement regarding computer programs involved in the performance of the tasks and services covered by this Contract.

XVI. INSURANCE

A. Provider agrees that in order to protect itself as well as Purchaser and La Crosse County, its officers, Boards, and employees under the indemnity provisions set forth in the paragraph above, Provider will at all times, during the terms of this contract, keep in force insurance policies issued by an insurance company authorized to do business and licensed in the State of Wisconsin. Unless otherwise specified in Wisconsin Statutes, the types of insurance coverage and minimum amounts shall be as follows:

Workers' Compensation: minimum amount statutory

Comprehensive general liability: $1,000,000 per occurrence and in aggregate for bodily injury and property damage

Auto Liability (if applicable): $1,000,000 per occurrence and in aggregate for bodily injury and property damage

Professional Liability (if applicable): minimum amount $500,000

Excess Liability Coverage: $1,000,000 over the General Liability and Automobile Liability Coverage's.

B. The Purchaser shall be given thirty (30) days advanced written notice of any cancellation or non-renewal of insurance during the term of this contract. Upon execution of this contract, the Provider will furnish Purchaser with written verification of the existence of such insurance. In the event of any action, suit, or proceedings against Purchaser upon any matter herein indemnified against, Purchaser shall within five (5) working days cause notice in writing thereof to be given to Provider by certified mail, addressed to its post office address. Purchaser shall cooperate with Provider and its attorneys in defense of any action, suit or other proceeding.

XVII. AUDIT REQUIREMENTS (see Appendix 3 for specific requirements):

A. The Provider shall submit an annual agency-wide or program audit to the Purchaser if the total amount of annual governmental funding through this and other contracts is $75,000 or more.

B. Providers with annual governmental funding through this and other contracts between $25,000 and $75,000 will be required to submit an annual income and expense statement to the Human Services Department as stated in La Crosse County Resolution 48-7/03.

C. Exception to requirement in XVII.A. and B. above: Residential Care Centers or Group Homes licensed under HFS 52 and HFS 57, respectively are required to submit an audit to the Purchaser if the total amount of annual governmental funding through this and other contracts is $25,000 or more. Audits are an essential part of the process for DHFS's claim to the federal government for Foster Care IV-E and Title XIX to help pay for care for children in these facilities who are eligible for those programs.

D. The audit shall be in accordance with the requirements of OMB Circular A-133 "Audits of State, Local Government, and Non-Profit Organizations" (online at www.whitehouse.gov/omb/circulars) if the Provider meets the criteria of that Circular for needing an audit in accordance with that Circular. The audit shall also be in accordance with:
-The State Single Audit Guidelines (www.ssag.state.wi.us), if the provider is a local government that meets the criteria of OMB Circular A-133 for needing an audit in accordance with that Circular or
-The Provider Agency Audit Guide (www.dhfs.state.wi.us/grants), 1999 revision, for all other providers.

E. The Provider agrees to deliver to the Purchaser one copy of the resultant audit report or Income and Expense Statement no later than 180 days after the completion of the Provider's fiscal year.

F. With the exception of governmental entities organized under s. 59.01, 66.013, 38.01, 139.30, or 117.01, Wis. Stats., the Purchaser shall notify the Provider within 180 days of receipt of the audit completed by the independent auditor, whether or not the audit meets the requirements of the DHFS audit guidelines.

G. In the event that the Provider fails to have an appropriate audit performed or fails to provide a complete audit report to the Purchaser within the specified timeframes, the Purchaser may:
    1. Conduct an audit or arrange for an independent audit of the Provider and charge the cost of completing the audit to the Provider;
    2. Charge the Provider for all loss of Federal or State aid or for penalties assessed to the Purchaser because the Provider did not submit a complete audit report within the required time frame;
    3. Disallow the cost of audits that do not meet these standards;
    4. Withhold payment, cancel the contract, or take other actions deemed by the Purchaser to be necessary to protect the Purchaser's interests.

H. When contracting with an audit firm, Provider shall authorize its auditors to provide access to work papers, reports, and other materials generated during the audit to the appropriate representatives of the Purchaser and the DHFS/DWD. Such access shall include the right to obtain copies of work papers and computer disks, or other electronic media, upon which records/working papers are stored.

I. Since contracts with group homes and child caring institutions for out-of-home care for children AND adult family homes and CBRF's for residential care for adults constitute a vendor relationship, they are not subject to OMB Circular A-133, although these agencies may still need to have A-133 audits if they are non-profit and if they expend more than $300,000 in federal awards for other activities. Therefore, group home, child caring institutions, adult family homes and community-based residential facilities will typically need to have audits in accordance with just the provisions of the Provider Agency Audit Guide.

J. If Provider feels that a waiver of the audit requirement should be granted, Provider must initiate the waiver request before the Purchase of Service Contract is signed by the Provider. Providers of Title 19 ONLY Services for CMO (Care Management Organization) members have been granted a Waiver by the State of Wisconsin. If Provider performs both Title 19 services and Non-Title 19 services, an audit is required only if the reimbursement for Non-Title 19 services amounts to $75,000 or more.

XVIII. ELIGIBILITY STANDARDS FOR RECIPIENTS OF SERVICES:

A. Provider and Purchaser understand and agree that the eligibility of individuals to receive the services to be purchased under this contract from Provider will be determined by Purchaser. An individual is entitled to the right of an administrative hearing concerning eligibility and the Purchaser shall inform individuals of this right.

XVIV. CIVIL RIGHTS COMPLIANCE/LIMITED ENGLISH PROFICIENCY:

A. The Civil Rights Compliance Plan contains three components that cover Affirmative Action, Civil Rights/Equal Opportunity, and Language Access. Providers that have more than twenty-five (25) employees and receive more than twenty-five thousand dollars ($25,000) must submit a Civil Rights Compliance plan with all three components mentioned above.

B. **Affirmative Action Plan.** For agreements of where the Provider has twenty five (25) employees or more and twenty-five thousand ($25,000) or more, the Provider shall submit a written Affirmative Action (AA) Plan, which may cover a two or three-year period. Providers with an annual work force of less than twenty-five (25) employees and Providers that are governmental entities are excluded from the requirement to submit an AA plan. Other exemptions from submitting an Affirmative Action Plan are Providers that have a balanced work force. Exempted Providers that do not have a balanced work force in specific job groups are required to develop and submit a recruitment strategy to address under-representation of that job group.

"Affirmative Action Plan" is a written document that details an affirmative action program. Key parts of an affirmative action plan are:

i. a policy statement pledging nondiscrimination and affirmative action employment,
ii. internal and external dissemination of the policy
iii. assignment of a key employee as the equal opportunity officer
iv. a workforce analysis that identifies job classifications where representation of women, minorities and the disabled is deficient,
v. goals and timetables that are specific and measurable and that are set to correct deficiencies and to reach a balanced workforce,
vi. revision of employment practices to ensure that they do not have discriminatory effects, and
vii. establishment of internal monitoring and reporting systems to measure progress regularly.

In addition, for agreements of twenty-five thousand ($25,000) or more and with twenty-five (25) employees, the Provider shall conduct, keep on file and update annually, a separate and additional accessibility self-evaluation of all programs and facilities, including employment practices for compliance with the Americans with Disabilities Title 1 regulations, unless an updated self-evaluation under Section 503 of the Rehabilitation Act of 1973 exists which meets the ADA requirements. For technical assistance on all aspects of Civil Rights Compliance, Providers are to contact the Department of Health and Family Services Affirmative Action/Civil Rights Compliance Office at (608)266-9372 (voice), (608)266-2555 (TDD), or write to the Department of Health and Family Services, 1 W. Wilson Street, Room 55, P.O. Box 7850, Madison, WI 53707-7850.

C. **Civil Rights Plan.** For agreements for the provision of services to clients, the Provider must comply with Civil Rights requirements. Providers with an annual work force of less than twenty-five (25) employees or receive less than $25,000 are not required to submit a Civil Rights Compliance Plan, but must, at a minimum, submit a Letter of Assurance that the Provider will comply with all federal and state laws that address nondiscrimination in service delivery.

The Provider assures that it has submitted to the Purchaser's Affirmative Action/Civil Rights Office a current copy of its two or three-year Civil Rights Compliance Plan for meeting equal opportunity requirements under Title VI and VII of the Civil Rights Act of 1964, Sections 503 and 504 of the Rehabilitation Act of 1973, Title VI and XVI of the Public Health Service Act, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the Omnibus Reconciliation Act of 1981, the Americans with Disabilities Act (ADA) of 1990, and the Wisconsin Fair Employment Act. If a Plan was reviewed and approved during the previous year, a plan update must be submitted for this contract period.

1. No otherwise qualified person shall be excluded from participation in, be denied the benefits of, or otherwise be subject to discrimination in any manner on the basis of race, color, national origin, sexual orientation, religion, sex, disability or age. This policy covers eligibility for and access to service delivery, and treatment in all programs and activities. All employees of the Provider are expected to support goals and programmatic activities relating to nondiscrimination in service delivery.
2. No otherwise qualified person shall be excluded from employment, be denied the benefits of employment or otherwise be subject to discrimination in employment in any manner or term of employment on the basis of age, race/ethnicity, religion, sexual orientation, color, sex, national origin or ancestry, disability(as defined in Section 504 of the Rehab Act and the Americans with Disabilities Act), arrest or conviction record, marital status, political affiliation, military participation, the use of legal products during non-work hours, non-job related genetic and honesty testing. All employees are expected to support goals and programmatic activities relating to non-discrimination in employment.
3. The Provider shall post the Equal Opportunity Policy, the name of the Equal Opportunity Coordinator and the discrimination complaint process in conspicuous places available to applicants and clients of services, and applicants for employment and employees. The complaint process will be according to the Department's standards and made available in languages and formats understandable to applicants, clients and employees. The Purchaser will continue to provide appropriate translated program brochures and forms for distribution.
4. The Provider agrees to comply with the Purchaser's guidelines in the Civil Rights Compliance Standards and a Resource Manual for Equal Opportunity in Service Delivery and Employment for the Wisconsin Department of Health and Family Services, its Service Providers and their Subcontractors (January 1, 2003, to December 31, 2004, edition).
5. Requirements herein stated apply to any subcontracts or grants. The Provider has primary responsibility to take constructive steps, as per the CRC Standards, to ensure the compliance of its subcontractors. However, where the Provider has a direct contract with another agency, the Provider need not obtain a Subcontractor or Subgrantee Civil Rights Compliance Plan or monitor that Subgrantee.
6. The Purchaser will monitor the Civil Rights Compliance of the Provider. The Purchaser will conduct reviews to ensure that the Provider is ensuring compliance by its subcontractors or grantees according to guidelines in the CRC Standards. The Provider agrees to comply with Civil Rights monitoring reviews, including the examination of records and relevant files maintained by the Provider, as well as interviews with staff, clients and applicants for services, subcontractors, grantees, and referral agencies. The reviews will be conducted according to Department of Health and Family Services procedures. The Purchaser will also conduct reviews to address immediate concerns of complainants.
7. The Provider agrees to cooperate with the Purchaser in developing, implementing and monitoring corrective action plans that result from complaint investigations or monitoring efforts.

B. **Language Access Plan.** For person with disabilities, the Provider agrees that it will:
1. Provide competent sign language interpreters for deaf and hard of hearing participants free of charge at any stage of application or receipt of services;
2. Provide aids, assistive devices and other reasonable accommodations to the client during the application process, in the receipt of services, and in the processing of complaint or appeals;
3. Train staff in human relations techniques, sensitivity to person with disabilities and sensitivity to cultural characteristics;
4. Make programs and facilities accessible, as appropriate, through outstations, authorized representatives, adjusted work hours, ramps, doorways, elevators, or ground floor rooms, and Braille, large print or taped information for the visually or cognitively impaired;

5. Post and/or make available informational materials in formats appropriate to the needs of the client population.

For Limited English Proficient (LEP) participants, the Provider agrees that it will:

1. Analyze its service area to assess the primary language needs of the participants that it serves or likely to serve;
2. Establish a plan that will make oral interpretation available and free of charge upon request;
3. Disseminate written notice in the primary language of the LEP group that interpretation is available and free of charge to groups that constitute less that 100 individuals eligible to be served or likely to be served;
4. Provide written translations of vital documents to LEP participants that constitutes at least 5% or 1,000 LEP individuals whichever is less, for the populations served or likely to be served. A vital document is any document that allows meaningful and equal access to Provider's programs and benefits;
5. Train staff about the Provider's LEP policies and procedures;
6. Collect data on primary language use of LEP participants to evaluate the program's effectiveness; and
7. Identify the LEP Coordinator and establish a complaint process that is accessible to LEP participants.

XX. CAREGIVER BACKGROUND CHECKS:

A. Provider shall comply with the provisions of HFS 12, Wis. Admin Code.
B. Provider shall conduct background checks at its own expense of all employees assigned to do work for the Purchaser under this contract if such employee has actual, direct contact with the clients of the Purchaser. Provider shall retain in its Personnel Files all pertinent information, to include a Background Information Disclosure Form and/or search results from the Department of Justice, the Department of Health and Family Services, and the Department of Regulation and Licensing as well as out of State records, tribal court proceedings and military records.
C. Provider shall not assign any individual to conduct work under this contract who does not meet with requirement of this law.
D. Provider shall maintain the results of background checks on its own premises for at least the duration of the contract. Purchaser may audit Provider Personnel files to assure compliance with the State of Wisconsin Caregiver Background Check Policy.
E. After the initial background check at the time of employment, licensure or contracting, the Provider must conduct a new Caregiver Background Check every four (4) years, or at any time within that period if the Provider has reason to believe a new check should be obtained.
F. The Provider shall notify the Purchaser in writing via certified mail within one (1) business day if an employee has been charged with or convicted of any crime specified in HFS 12.07(2).

XXI. CONDITIONS OF THE PARTIES OBLIGATIONS:

A. This contract is contingent upon authorization of Wisconsin and United States laws and any material amendment or repeal of the same affecting relevant funding or authority of the Wisconsin Department of Health and Family Services shall serve to terminate this contract, except as further agreed to by the parties hereto. This contract is not assignable by Provider either in whole or in part, without the prior written consent of Purchaser.
B. Nothing contained in this contract shall be construed to supersede the lawful powers and duties of either party.
C. It is understood and agreed that the entire contract between the parties is contained herein, except for those matters incorporated herein by reference, and that this contract supersedes all oral agreements and negotiations between the parties relating to the subject matter thereof.

XXII. CONTRACT REVISIONS, RENEWAL, AND/OR TERMINATIONS:

A. Failure to comply with any part of this Contract may be considered cause for revision, suspension or termination.
B. Revision of this contract must be agreed to by Purchaser and Provider by an addendum signed by the authorized representatives of both parties.
C. This contract may be terminated or suspended due to deficiencies in quality or quantity of services. Provider shall notify Purchaser, in writing, whenever it is unable to provide the required quality or quantity of services. Upon such notification, Purchaser and Provider shall determine whether such inability will require a revision or early termination of this Contract.
D. If Purchaser finds it necessary to terminate the contract prior to the contract expiration date for reasons other than non-performance by the Provider, the Purchaser may compensate the Provider for an amount determined by mutual agreement of both parties.
E. This contract can be terminated by 60-day written notice by either party.
F. In the event that the contract is terminated or not renewed by either Purchaser or Provider, Provider agrees to cooperate in transitioning services provided to eligible clients under this contract to Purchaser or to another Provider designated by Purchaser.
G. This Contract, or any part thereof, may be renegotiated in the case of 1) increased or decreased volume of services; 2) changes required by Federal or State law or regulations or court action; 3) monies available affecting the substance of this contract.
H. The Purchaser reserves the right to cancel any contract in whole or in part without required notice and without penalty due to non-appropriation of funds by the State of Wisconsin, County of La Crosse or any other funding source.
I. Chapter 50.03(14), Wis. Stats., governs the closing of a Community Based Residential Facility (CBRF). It states that, upon DHFS approval of the facility's plan to relocate its residents (or the imposition of such a plan by the DHFS), the facility must establish a closing date not earlier than 90 days from the date of DHFS approval or imposition of the relocation plan when 5 to 50 residents will be relocated. This same statute also requires a minimum of 120 day period when more than 50 residents will be relocated.

XXIII. HIPAA COMPLIANCE

A. The Provider agrees to comply with the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to the extent those regulations apply to the services the Provider provides or purchases with funds provided under this contract.
B. If Provider is considered to be a "Business Associate", as determined by the Purchaser, the Provider will receive a Business Associate Agreement under separate cover.

XXIV. APPENDICES

A. The following Appendices preceded by an "X" are attached and considered part of this Contract:

__X__ Appendix 1 – Reimbursement for Authorized Services

_____ Appendix 2 – Service Authorization Procedures by Section

__X__ Appendix 3 – Audit Requirements

__X__ Appendix 4 – Certification Regarding Debarment and Suspension (sign and return)

__X__ Appendix 5 – Certification Regarding Lobbying (sign and return)

_____ Appendix 6 – W-2 Contract Requirements (fill out and return)

_____ Appendix 7 – CMO Contract Requirements

_____ Appendix 8 – CMO Provider Performance Measures (Vocational Services, Residential Services, Adaptive Aids, Disposable Medical Supplies, Durable Medical Equipment)

XXV. SIGNATURES:

A. This contract is agreed upon and approved by the authorized representatives of La Crosse County Department of Human Services and ABC Corporation.
B. The parties in execution of this contract certify that each has lawful authority to enter the agreement and that each has read and agreed to abide by all of its terms.
C. This contract becomes null and void if the time between the Purchaser's authorized representative signature and the Provider's authorized representative signature on this contract exceeds 60 days.

_____ _____

Provider's Authorized Representative Date
Title:

_____ _____

Purchaser's Authorized Representative Date
County Board Chair

_____ _____

Purchaser's Authorized Representative Date
Human Services Director

APPENDIX 1(Page 1) – REIMBURSEMENT FOR AUTHORIZED SERVICES

PURCHASER AND PROVIDER AGREE:
Reimbursement for authorized services provided to eligible clients will be determined in accordance with this Appendix.

No Minimum Requirement – It is understood and agreed by the parties that the Purchaser assumes no obligation to purchase from Provider any minimum amount of services as defined in the terms of this contract.

Method of Payment – For clarification of Method of Payment Code, refer back to Section V, Letter A. 1/12th payments (Method of Payment Code #2) are exceptions to being paid under the normal provisions of the contract. When MOP below is #2, it will also state a date of when reconciliation between the contracted payments and the authorized/delivered units will occur. If the reconciliation reveals that the calculation of the payment based on the Provider's authorized units delivered at the agreed upon rate(s) exceed the 1/12th payments made, the Purchaser will then issue a payment to the Provider. If the reconciliation reveals that the Purchaser's 1/12th payments exceeded the calculation of the payments based on the Provider's authorized units delivered at the agreed upon rate(s), the Purchaser will require the Provider to refund the difference or will subtract the difference from future checks. The exact process for the Purchaser to recapture the amount owed will be mutually decided upon between both parties at the time of reconciliation, dependent upon the amount owed and the impact that it will have on the Provider's service delivery. All funds should be recaptured by December 31st of the current year.

CMO Providers - Adjustments in reimbursement are applicable to retroactive rates determined by Medicaid for Medicaid State Plan Covered Services.

Hours should be rounded to the nearest ¼ hour, unless otherwise stated in MA Guidelines (i.e. Personal Care should be rounded to the nearest ½ hour). Purchaser will pay for date of admission and not the date of discharge.

Total Cost – The Provider agrees that the total amount to be paid pursuant to the Contract shall not exceed an amount equal to the number of authorized actual units of service delivered by the Provider multiplied by the appropriate unit rate set forth in the following schedule of rates:

Service Description	Rate	Unit	Method of Payment

APPENDIX 1(Page 2)

Service Description	Rate	Unit	Method of Payment

APPENDIX 1(Page 3)

Service Description	Rate	Unit	Method of Payment

APPENDIX 2 (1) - CMO SERVICE AUTHORIZATION:

A. Provider agrees to comply with Purchaser's process to receive required prior authorization for providing the services under this contract.

B. All services provided to eligible clients under this Contract must be authorized by Purchaser prior to the delivery of services, (unless exceptions have been made with the provider or group of providers) and the total services provided each month to individual clients under this Contract may not exceed the amounts authorized by Purchaser. A Care Management Team (CMT) and the eligible client and/or their chosen representative will develop an Individual Service Plan (ISP). The ISP will specify each and every service to be authorized by the Purchaser. Initially, a verbal authorization will be given by the CMT which should be documented by the provider. A written (and/or electronic) authorization for each and every service to be provided will be sent (either electronically or via mail) to the service provider specifying the specific service to be provided, the amount of service (number of units) to be provided, the rate to be paid for the service, the funding source and the duration of the service to be provided. Provider may request additional service authorization(s) (new/additional service(s)) or extensions of existing authorizations by contacting the lead Social Worker. Requests for new/additional or extensions of existing authorizations MAY be considered by the Purchaser, but the mere factor of a request does not in any way imply that there will be any change in service level, service type or duration of service. The final decision for any change or increase in services rests with the Purchaser and the eligible client.

C. It is understood that the final authority for determining client eligibility for service and the amount of services to be provided to individual clients rest with Purchaser and that Provider will not be reimbursed for unauthorized services provided to clients or provided in amounts that exceed those authorized for individual clients. Also, Provider will not be reimbursed for providing services to clients who have dis-enrolled or have lost their eligibility for services, if such services have been provided after the Provider receives notice of such dis-enrollment or loss of eligibility.

D. Provider must comply with Purchaser's Service Authorization Procedures to be reimbursed for client services provided under this contract.

E. Provider agrees to provide services to clients each month only in the amounts authorized by Purchaser and to accept full responsibility for the cost of any services provided by Provider that exceed the amounts authorized by Purchaser. Under no circumstances shall Provider seek payment from Purchaser, or client, for the cost of services exceeding the total amount(s) authorized under this Contract.

F. Provider agrees that services will be available to eligible clients throughout the entire period of this Contract and to accept all clients referred by Purchaser as long as Provider has capacity to serve authorized clients.

G. Provider may not transfer a client from one category of care or service to another without written authorization by the Purchaser. In case of urgent or emergency service need, telephone authorization will be permitted.

H. In instances when the Provider feels that a client needs additional services immediately, due to a change in condition or level of care, the Provider may get this prior authorization by contacting the care management team (or case manager) during regular business hours. If the prior authorization is needed outside of regular business hours, the Provider can contact the on-call case manager by phone. The Purchaser will furnish the Provider the phone number to use in such instances.

I. Purchaser reserves the right to withdraw any client from the program, service, institution or facility of the Provider at any time when in the judgment of Purchaser it is in the best interest of Purchaser or the client to do so.

J. Provider shall notify its providers, if applicable, of different procedures than A-I.

APPENDIX 2 (2) - FAMILY AND CHILDREN'S SECTION SERVICE AUTHORIZATION:

A. Provider agrees to comply with Purchaser's process to receive required prior authorization for providing the services under this contract.

B. All services provided to eligible clients under this Contract must be authorized by Purchaser prior to the delivery of services, and the total services provided each month to individual clients under this Contract may not exceed the amounts authorized by Purchaser. A Social Worker and the eligible client will develop a Treatment Plan. An Individual Service Authorization (ISA) will specify each and every service to be authorized by the Purchaser. A written (and/or electronic) authorization for each and every service to be provided will be sent (either electronically or via mail) to the service provider specifying the specific service to be provided, the amount of service (number of units) to be provided, the rate to be paid for the service, the funding source and the duration of the service to be provided. Provider may request additional service authorization(s) (new/additional service(s)) or extensions of existing authorizations by contacting the Social Worker. Requests for new/additional or extensions of existing authorizations MAY be considered by the Purchaser, but the mere factor of a request does not in any way imply that there will be any change in service level, service type or duration of service. The final decision for any change or increase in services rests with the Purchaser.

C. It is understood that the final authority for determining client eligibility for service and the amount of services to be provided to individual clients rest with Purchaser and that Provider will not be reimbursed for unauthorized services provided to clients or provided in amounts that exceed those authorized for individual clients. Also, Provider will not be reimbursed for providing services to clients who have lost their eligibility for services, if such services have been provided after the Provider receives notice of loss of eligibility.

D. Provider must comply with Purchaser's Service Authorization Procedures to be reimbursed for client services provided under this contract.

E. Provider agrees to provide services to clients each month only in the amounts authorized by Purchaser and to accept full responsibility for the cost of any services provided by Provider that exceed the amounts authorized by Purchaser. Under no circumstances shall Provider seek payment from Purchaser, or client, for the cost of services exceeding the total amount(s) authorized under this Contract.

F. Provider agrees that services will be available to eligible clients throughout the entire period of this Contract and to accept all clients referred by Purchaser as long as Provider has capacity to serve authorized clients.

G. Provider may not transfer a client from one category of care or service to another without written authorization by the Purchaser. In case of urgent or emergency service need, telephone authorization will be permitted.

H. In instances when the Provider feels that a client needs additional services immediately, due to a change in condition or level of care, the Provider may get this prior authorization by contacting the Social Worker/Supervisor during regular business hours. If the prior authorization is needed outside of regular business hours, the Provider can contact the on-call Social Worker by phone. The Purchaser will furnish the Provider the phone number to use in such instances.

I. Purchaser reserves the right to withdraw any client from the program, service, institution or facility of the Provider at any time when in the judgment of Purchaser it is in the best interest of Purchaser or the client to do so.

J. Provider shall notify its providers, if applicable, of different procedures than A-I.

APPENDIX 2 (3) - CLINICAL SERVICES SECTION SERVICE AUTHORIZATION:

A. Provider agrees to comply with Purchaser's process to receive required prior authorization for providing the services under this contract.

B. All non-emergency services provided to eligible clients under this Contract must be authorized by Purchaser prior to the delivery of services and the total services provided each month to individual clients under this Contract may not exceed the amounts authorized by Purchaser. Detoxification and Crisis Stabilization services do not require prior authorization but do require that the purchaser be notified within 24 hours of the initiation of the service, exclusive of weekends and holidays. The Crisis Mobile Outreach Service must be notified before admissions to Mental Health Inpatient Services. A written (and/or electronic) authorization will be furnished to the service provider specifying the service to be provided, the amount of service (number of units) to be provided and/or the duration of the service to be provided. Provider may request additional service authorization(s) or extensions of existing authorizations by contacting the case manager. Requests for new/additional or extensions of existing authorizations MAY be considered by the Purchaser, but the mere factor of a request does not in any way imply that there will be any change in service level, service type or duration of service. The final decision for any change or increase in services rests with the Purchaser.

C. It is understood that the final authority for determining client eligibility for service and the amount of services to be provided to individual clients rest with Purchaser and that Provider will not be reimbursed for unauthorized services provided to clients or provided in amounts that exceed those authorized for individual clients. Also, Provider will not be reimbursed for providing services to clients who have lost their eligibility for services, if such services have been provided after the Provider receives notice of such loss of eligibility.

D. Provider must comply with Purchaser's Service Authorization Procedures to be reimbursed for client services provided under this contract.

E. Provider agrees to provide services to clients each month only in the amounts authorized by Purchaser and to accept full responsibility for the cost of any services provided by Provider that exceed the amounts authorized by Purchaser. Under no circumstances shall Provider seek payment from Purchaser, or client, for the cost of services exceeding the total amount(s) authorized under this Contract.

F. Provider agrees that services will be available to eligible clients throughout the entire period of this Contract and to accept all clients referred by Purchaser as long as Provider has capacity to serve authorized clients.

G. Provider may not transfer a client from one category of care or service to another without written authorization by the Purchaser.

H. In instances when the Provider feels that a client needs additional services immediately, due to an emergency, the Provider may follow the procedures for emergency services above. Assistance with emergencies can be obtained by contacting the Crisis Mobile Outreach worker. The Purchaser will furnish the Provider with information on how to access Mobile Outreach.

I. Purchaser reserves the right to withdraw any client from the program, service, institution or facility of the Provider at any time when in the judgment of Purchaser it is in the best interest of Purchaser or the client to do so.

J. Provider shall notify its providers, if applicable, of different procedures than A-I.

APPENDIX 3 (1)

AUDIT REQUIREMENTS

Reporting Package: The Provider shall submit to the Purchaser a reporting package that includes: (a) all audit schedules and reports required for the type of audit applicable to the agency; (b) a summary schedule of prior year findings and the status of addressing these findings; (c) a Management Letter (or similar document conveying auditor's comments issued as a result of the audit); (d) management responses/corrective action plan for each audit issue identified in the audit.

Program Specific Audit Requirements

The following reports and schedules should be included in a program specific audit:

a. Independent Auditors' Report on the financial statements.
b. Independent Auditors' Report on the internal control structure based on an audit performed in accordance with Government Auditing Standards.
c. Independent Auditors' Report on compliance based on an audit performed in accordance with Government Auditing Standards.
d. Independent Auditors' Report on compliance with general requirements applicable to Federal and/or State financial assistance programs.
e. Independent Auditors' Report on supplementary information
f. Required financial statements.
g. Statement of revenue and expense by funding source and disclosure of actual units of service provided.
h. For sub-recipients not on a calendar year, a schedule to tie out the contract year.
i. For CCI's and incorporated group homes, refer to Wisconsin DHSS Provider Agency Audit Guide for additional required schedules.
j. Schedule of findings and questioned costs.
k. Management letter and management responses.

A-133 AND A-128 AUDIT REQUIREMENTS

l. Independent Auditors' Report on internal control structure used in administering Federal and /or State financial assistance programs (accounting and administrative controls.
m. Independent Auditors' Report on compliance with specific requirements applicable to major Federal and/or State financial assistance programs.
n. Independent Auditors' Report on compliance with specific requirements applicable to non-major Federal and/or State financial assistance programs.
o. Schedule of Federal and/or State financial assistance. A breakdown by CFDA# of the amount received can be obtained from the County at year-end.

APPENDIX 3 (2)

Specific Audit Requirements For Non-Profit and Governmental Entities

A. Provider must cooperate with the Purchaser in establishing costs for reimbursement purposes.
B. An entity that receives less than $25,000 in State funding is not required to have an audit of any kind.
C. An entity that receives less than $75,000, but more than $25,000 in governmental funding through this and other contracts, is required to submit a Statement of Income and Expenses. (Please see Section XVII.C. of the Contract for the exception to this)
D. An entity that receives less than $300,000 in Federal funds, but more than $75,000 in Federal or State funding is not required to have a single audit, but rather an audit in accordance with the Provider Agency Audit Guide and Government Auditing Standards. (Please see Section XVII.C. of the Contract for the exception to this); unless an entity that receives at least $300,000 in Federal funding must have a single audit in accordance with the Federal compliance supplement OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations, the Wisconsin Department of Health and Family Services' Provider Agency Audit Guide, and if a governmental agency, The State of Wisconsin Single Audit Guidelines.
E. The sub-recipient may choose to have a program specific audit (See Appendix 3 (1)) when Federal funding is greater than $300,000 and the funding is received from only one funding source.
F. Provider must maintain a uniform double entry accounting system compatible with cost accounting and control systems. (See DHFS Accounting Principles and Allowable Cost Policies Manual, Division of Management Services.)
G. Provider may transfer a client from one category of care or service to another only with the approval of the Purchaser. Fiscal sanctions imposed on Purchaser due to Provider's errors or omissions shall be passed on to Provider.
H. The Provider agrees to comply with all applicable statutes and regulations that define the rights of participants. The Provider will actively foster these rights by incorporating them into facility management, philosophy, programming, training and personal instruction.
I. Non-profit providers shall include a Reserve Supplemental Schedule (Section 7.1.6 of the PAAG) in their audit reports and this schedule shall also be by contract or service category.

APPENDIX 3 (3)

Specific Audit Requirements For Hospitals and Clinics

A. Provider must cooperate with the Purchaser in establishing costs for reimbursement purposes.
B. Provider must comply with Federal and State audit requirements.
C. A sub-recipient that receives less than $25,000 a year in Federal and State funded programs is not required to have an audit of any kind.
D. A sub-recipient that receives less than $75,000, but more than $25,000 in governmental funding through this and other contracts, is required to submit a Statement of Income and Expenses.
E. As a hospital or clinic and a sub-recipient of at least $75,000 a year in Federal and State funded programs, the Provider must have an audit conducted in accordance with the provisions of the Government Auditing Standards and the Wisconsin DHFS Provider Agency Audit Guide.
F. An amendment to this contract during the contract year may change the Provider's audit requirements. The required audit reports and schedules (See Appendix 3(1)) shall be submitted to Purchaser no later than 180 days following the close of the Provider's fiscal year.
G. Provider must maintain a uniform double entry accounting system compatible with cost accounting and control systems. (See DHFS Accounting Principles and Allowable Cost Policies Manual, Division of Management Services.)
H. Provider may transfer a client from one category of care or service to another only with the approval of the Purchaser. Fiscal sanctions imposed on Purchaser due to Provider's errors or omissions shall be passed on to Provider.

APPENDIX 3 (4)

Specific Audit Requirements For For-Profit Entities

A. Provider must cooperate with the Purchaser in establishing costs for reimbursement purposes.
B. Provider must comply with Federal and State audit requirements.
C. A sub-recipient that receives less than $25,000 a year in State funded programs is not required to have an audit of any kind.
D. An entity that receives less than $75,000, but more than $25,000 in governmental funding through this and other contracts, is required to submit a Statement of Income and Expenses. (Please see Section XVII.C. of the Contract for the exception to this)
E. As a for-profit agency and a sub-recipient of less than $300,000, but more than $75,000 in State funded programs, the provider must have an audit conducted in accordance with the provisions of the Government Auditing Standards and the Wisconsin DHFS Provider Agency Audit Guide. (Please see Section XVII.C. of the Contract for the exception to this)
F. A for-profit agency and a sub-recipient of at least $300,000 a year in Federal funding must have a single audit in accordance with the Federal compliance supplement OMB Circular A-133, Audits of States, Local Government, and Non-Profit Organizations, the Wisconsin Department of Health and Family Services' Provider Agency Audit Guide, and if a governmental agency, the State of Wisconsin Single Audit Guidelines.
G. An amendment to this contract during the contract year may change the Provider's audit requirements. The required audit reports and schedules (See Appendix 3(1)) shall be submitted to Purchaser no later than 180 days following the close of the Provider's fiscal year.
H. Provider must maintain a uniform double entry accounting system compatible with cost accounting and control systems. (See DHFS Accounting Principles and Allowable Cost Policies Manual, Division of Management Services.)
I. Provider may transfer a client from one category of care or service to another only with the approval of the Purchaser. Fiscal sanctions imposed on Purchaser due to Provider's errors or omissions shall be passed on to Provider.
J. For-profit providers shall include a schedule in their audit reports showing the total allowable costs and the calculation of the allowable profit by contract or by service category.

APPENDIX 3 (5)

WAIVER OF THE AUDIT REQUIREMENT

The Purchaser has waived the audit requirement under s.46.036, s.49.34, or s.301.08 for this contract. This provision does not absolve the provider from needing to meet any federal audit requirements that may be applicable or any audit requirements of other contracts.

Providers of Title 19 ONLY Services for CMO members have been granted a waiver by the State of Wisconsin (a waiver request from these Providers is not required).

APPENDIX 4
CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant defined as the primary participant in accordance with 45 CFR Part 76, and its principles:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transactions by any Federal department or agency.

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (Federal, State, or local) transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statement, or receiving stolen property;

(c) are not presently indicated or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page.

The applicant agrees that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion-Lower Tier Covered Transaction". Appendix B to 45 CFR Part 76 in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions.

BY _____ Date _____

(Signature of official authorized to sign)

APPENDIX 5
CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements
The undersigned certifies, to the best of his or her knowledge and belief, that

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

By: _____ Date: _____
(Signature of Official Authorized to Sign Application)

For: _____
Name of Provider

_____
Title of Program(s)

APPENDIX 6
W-2 CONTRACT REQUIREMENTS

1. Services to be Provided

Subject to the terms and conditions set forth in the Wisconsin Works (W-2) Contract, Purchaser agrees to purchase and Provider agrees to provide to eligible participants the services as described in detail in this Contract.

For all contracts between an agency administering programs supervised by the Division of Economic Support (DES) and a Provider, the services to be provided for agency participants shall be stated by the Provider to the Purchaser. (Provider needs to fill in spaces below or attach a separate sheet)

Specific W-2 services to be delivered: _____

Number of W-2 participants to receive such services: _____

Expected outcomes of services provided: _____

2. Monthly Reports

A) Provider agrees to provide the Purchaser with monthly report(s) relating to delivery of services under this contract which will include the following:

-Number of persons and families served
-Type of service provided

B) Provider agrees to comply with all DWD Cares data entry requirements.

3. Provider Responsibilities

Provider agrees to meet state and federal service standards and applicable state licensure and certification requirements as expressed by state and federal rules and regulations applicable to the services covered by this contractual agreement. In addition, Provider shall:

A) All services under this contract shall be provided in accordance with, but not limited to, the requirements of the federal Temporary Assistance for Needy Families (TANF), Wisconsin Works (W-2) and applicable Wisconsin Statutes. The services must be provided in conformity with applicable state and federal requirements and the State W-2 Plan as approved by the Family Support Administration of the U.S. Department of Health and Human Services. Provider must adhere to the requirements of applicable Department of Workforce Development (DWD) Administrative Rules, the W-2 Financial Management Manual, the Department's Policies and Procedures and the contract that the Purchaser has with DWD.

B) Provider agrees to cooperate with Purchaser in developing and maintaining procedures for linking case management functions with the W-2 agency.

C) Provider agrees to cooperate with Purchaser in coordinating local W-2 services with other Educational and Training programs in the designated service area.

D) The Provider agrees to cooperate in developing and maintaining procedures for an effective conciliation process to assure that W-2 enrollees are accorded an interview with an impartial staff person designed to air grievances and attempt conciliation so program activities can be utilized by the enrollee.

E) The parties agree that any loss or expense including costs and attorney fees imposed by law will be charged to the party responsible for the office, employee or agency whose actions caused the loss or expense.

4. Faith Based Contracting

A) The Purchaser will not require the faith-based Provider to alter its definition, development, practice or expression of its religious beliefs, nor shall it require the faith based Provider to alter its internal governance or remove religious art or any other expression of its religious belief.

B) The Purchaser will make available within a reasonable time an alternative provider of the same services, worth the same value, to any participant who objects to the religious character of the faith based Provider from which the participant would receive services or assistance.

C) The Purchaser shall require the faith based Provider meet all fiscal and accounting standards, and generally accepted accounting principles.

5. System Security

A) The Provider agrees to report services that are provided through the direct entry of data into DWD's automated reporting system. The Purchaser assures that any preliminary data entry required to enable the Provider to use DWD's automated reporting system (e.g., referral and enrollment data) be entered in a timely manner.

B) The Provider will need to follow the requirements outlined in the Security Manual to gain access to DWD's automated reporting system (http://dwdworkweb/dws/manauls/securitymanual.htm). The Provider must identify themselves as a 'subcontractor' when completing the Computer Access Request form (DES-10).

C) The Provider must assure adequate steps have been taken to safe guard sensitive client and administrative information contained in DWD's automated systems by meeting the standards set forth by DWD (http://dwdworkweb/dws/manuals/securitymanual.htm).

D) The Provider must assure adequate security for the network by meeting the standards set forth by DWD (http://www.dwd.state.wi.us/w2tech/network_security.htm).

6. Bonuses to Employees

The Provider will provide the Purchaser with a copy of the Provider's policies on bonuses to their employees. This policy needs to be attached as part of this signed contract.

7. Disclosure of Independence and Relationship

A) The Provider certifies that no relationship exists between the Provider and the Purchaser that interferes with fair competition or is a conflict of interest, and no relationship exists between the Provider and another person or organization that constitutes a conflict of interest with respect to this contract. If there is a conflict of interest, the Provider must notify the Purchaser's Contract Manager. The Purchaser will refer this notice from the Provider to the DWD's Contract Manager. The DWD Contract Manager may waive this provision in writing, if the activities of the Provider will not be adverse to the interest of the DWD.

B) The Provider agrees as part of this contract that during performance of this contract, the Provider will neither provide contractual services nor enter into any agreement to provide services to a person or organization that is funded by DWD or has interests that are adverse to the DWD. If there is a conflict of interest, the Provider must notify the Purchaser's Contract Manager. The Purchaser will refer this notice from the Provider to the DWD's Contract Manager. The DWD's Contract Manager may waive this provision, in writing, if the activities of the Provider will not be adverse to the interests of the DWD.

APPENDIX 7
CMO CONTRACT REQUIREMENTS

1. Definitions

A) Care Management Organization - CMO -- A Care Management Organization (CMO) is an entity that has been certified by the state as meeting the requirements for a care management organization under s. 46.284(3), Stats. and has a contract under s. 46.284(2), Stats.; and s. HFS 10.42. The CMO is an organization that has been certified by the Department of Health and Family Services to make available to members, in consideration of periodic fixed payments, certain long term care and health care services.

B) CMO Member -- A CMO member is a person voluntarily enrolled in a CMO after having been found to be financially and functionally eligible for services in the care management organization.

C) Service Authorization -- A service authorization is an official document sent by the Purchaser (electronically and/or by mail) to a service provider indicating that the Purchaser is willing to pay for the indicated service after it has been provided by the Provider to the client. A service authorization will indicate the name of the client authorized to receive the service; the type of service to be provided; the number of units (amount of service) to be provided; the rate to be paid per unit for the service; the duration of the authorization; and the funding source.

D) DHFS -- DHFS is the State of Wisconsin Department of Health and Family Services.

E) Clean Claims – Clean Claims are those claims that are submitted to the Purchaser which are completely and correctly filled out, and do not require correction, editing or resubmission by the claiming agency (the Provider of services.)

2. Payment

A) Purchaser shall pay 90% of claims that receive advanced authorization within thirty (30) days of receipt of a complete and accurate claim and 100% of those claims within ninety (90) days of receipt.

B) Provider agrees to follow Coordination of Benefits (COB) procedures established by the Wisconsin Office of the Commissioner of Insurance, acknowledging that the Purchaser is the secondary payer in circumstances where an eligible client is covered by a third party payer. If the Purchaser is not primary in a COB situation, the Provider will bill other primary third party payers first. In the event that the primary payer denies the claim or makes only a partial payment on the claim, the Provider will submit invoices to the Purchaser within forty-five (45) days of receiving the primary payer's denial or partial payment.

C) If the service is otherwise covered by Medical Assistance outside of the CMO, the Provider should also provide the Purchaser with the MA Procedure Code and the usual and customary fee (if applicable), along with elements of a clean claim from Section V.G. of the contract. (Please reference the CMO Handbook to see what is covered and not covered by the CMO).

3. Provider Responsibilities

A) Health professionals who are certified by Medicaid agree to provide information about their education, Board certification, and re-certification upon request of the Purchaser.

B) When providing services for eligible CMO members, Provider will use workers that:

1. Are certified by the Medicaid program for those services in the contract, which are Medicaid state, plan services;
2. Meet the standards of Wisconsin's Home and Community Based Waivers; or
3. Meet the Purchaser's provider standards, which have been approved by the State.

APPENDIX 8 (1)
La Crosse County Care Management Organization
Provider Performance Measures

Vocational Services (Supported Employment, Sheltered Employment, Prevocational, Day Services/DD only)

Business Operations	
Requirement/Expectation	**Measurement Methods**
1. Training (Safety, confidentiality, respectful treatment, knowledge of consumers, specialized target groups, staff requirements, provider performance measures, abuse & neglect policy)	Policy & Procedure Review of training materials
2. Business Communications (Authorizations, billing process, feedback process to discuss consumer issues)	Policy & Procedure Comparison of bills to authorizations
3. Service	Policy & Procedure Adherence to Waiver Standards Documentation of individualized service plans
4. Reporting Quarterly Reports submission timeline: Jan – Mar, due April 30 April – June, due July 31 July – Sept, due Oct 31 Oct – Dec, due Jan 31	Quarterly Reports submitted by the agency: 1) # of referrals of CMO members monthly and year-to-date total 2) # of CMO members served monthly and year-to-date total in these areas: job assessment, job development, supported employment/job coaching 3) # of CMO members who found jobs monthly and year-to-date total 4) # of CMO members who maintained jobs monthly and year-to-date total 5) # of job coaching hours per member per month Annual Reports submitted by agency: 1) Summary of 1 – 5 above 2) Results from consumer satisfaction review 3) Summary of specialty programs offered throughout the year 4) Staff turnover information

Consumer Outcomes	
Requirement/Expectation	**Measurement Methods**
1. Meaningful Activity (Variety of choices, flexibility)	Member outcome interviews Member Centered Plans
2. Service (timeliness, community integration, successful placement, consumer training)	Policy & Procedure Member Centered Plans
3. Member preferences honored	Member Satisfaction Survey Complaints and Grievances Feedback from Care Management Teams
4. Customer Satisfaction	Member Satisfaction Survey Feedback from Care Management Teams
5. Achievement of Member Goals	Member-Centered Plans Feedback from Care Management Teams

APPENDIX 8 (2)
La Crosse County Care Management Organization
Provider Performance Measures

Residential Providers (Nursing Homes, CBRFs, RCACs, Corporate AFHs)

Business Operations	
Requirement/Expectation	**Measurement Methods**
1. Licensing	• Survey results from licensing organization. (i.e. BQA) • Plan of Correction for any deficiencies. (to be obtained from the licensing organization)
2. Safety	• We will refer to licensing organization's review • Copies of reports sent to Licensing Organization related to critical incidents, medication errors and falls. (The provider should send these to the CMO when they submit to licensing organization.) • Follow CMO policy and procedure for reporting abuse and neglect. (see attached)
3. Staff Retention/Recruitment	• Staff turnover % per year • Staffing ratio per client
4. Communications with CMO	• Facility staff participation in CMO member planning if requested • CMO staff invited to client care plan meetings in a timely manner • CMO staff informed of all complaints & grievances filed by a CMO member/representative in a timely manner • CMO staff informed of health related issues in a timely manner, which might effect their ongoing placement in facility or may necessitate a possible discharge. • Accurate bills submitted in a timely manner • Demonstrate understanding of contract requirements, i.e., primary payers
5. Staff Training	• Provider submit copy of annual training plan (send to Nancy Schmidt by Dec. 31st for the following year)

Consumer Outcomes	
Requirement/Expectation	**Measurement Methods**
1. Safety	• Member Survey • Outcome Interviews • CMO Team and Family observations
2. Nutrition/Meals Meeting nutritional needs, providing for special diets Quality of meals (taste, preferences, temperature) Substitute food options available Member participation in menu planning Member assistance in meal preparation (as applicable)	• Weight loss/gain of clients (case manager observation and chart review) • Member survey • Review of treatment plan • CMO Team and Family observations
3. Respectful Treatment	• Member survey/Member outcome results • CMO Team and Family observations • Adherence to restraint policy/ utilization of restraints
4. Client Opportunities, Meaningful activity and Choice	• Review facility's calendar of events • Review choices of activities • Do clients choose their own daily routine – review of treatment plan • Member survey • Effectiveness of meeting goals on the member-centered plan
5. Privacy	• Does the client have the option for a private room • Member survey/Member outcome results • CMO Team and Family observations

APPENDIX 8 (3)
Family Care – La Crosse County Care Management Organization (CMO)
Provider Performance Measures

Adaptive Aids/DMS/DME

Business Operations

Requirement/Expectation	Measurement Methods
1. Staff Knowledge (function of equipment, alternatives/options, ability to assess member needs)	Employee Records Policy & Procedure
2. Equipment (regular repair/maintenance, cleaning, serviceability, warranty)	Records Policy & Procedure
3. Flexibility (trial usage of equipment, scheduling home visits)	Policy & Procedure Experience with vendor
4. Products (variety, “Quality”, Availability)	Policy & Procedure Complaints/feedback Measured via CMO care managers
5. Services (consumer training, set up, timely delivery)	Policy & Procedure Complaints/feedback
6. Training (safety, confidentiality, respectful treatment, knowledge of consumers, staff requirements & retention)	Policy & Procedure
7. Business Communications (Authorizations, billing process, medical vs. non-medical, third party payer)	Policy & Procedure Comparison of bills to authorizations
8. Medicare/Medicaid Certification	Policy on coordination of benefits

Adaptive Aids continued

Consumer Outcomes	
Requirement/Expectation	**Measurement Methods**
1. Member Satisfaction	Member survey Complaints & Grievances
2. Supplies appropriate product for consumer need	Member survey Authorized compared to assessment of need
3. Customer Service oriented (respectful, responsive to requests, offers choices)	Member survey Complaints & Grievances
4. Timely repair and maintenance of equipment	Member survey Complaints & Grievances